PRINTED: FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155605 06/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1959 E COLUMBUS ST **GRANDVIEW HEALTH & REHABILITATION CENTER** MARTINSVILLE, IN46151 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0000 Submission of this plan of F0000 This visit was for the Investigation of correction does not constitute Complaint IN00092324. admission or agreement by the provider of the truth of facts Complaint IN00092324-Substantiated, alleged or correction set forthon federal/state deficiencies related to the the statement of deficiencies. This plan of allegation are cited at F225 and F226. correction is prepared and submitted because of Survey dates: June 22 & 23, 2011 requirement under state and federal law. Please accept this plan of correction as our credible Facility number: 000400 allegation of compliance. We are Provider number: 155605 requesting paper compliance. AIM number: 100266880 Survey team: Joyce Hofmann, RN Census bed type: SNF: 8 SNF/NF: 56 Total: 64 Census payor type: Medicare: 13 Medicaid: 44 Other: 7 Total: 64 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RCFV11

Facility ID:

000400

TITLE

If continuation sheet

07/11/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155605		(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION  00	(X3) DATE COMPL 06/23/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
GRANDV	/IEW HEALTH & RE	HABILITATION CENTER		1	COLUMBUS ST NSVILLE, IN46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	Quality review of 2011 by Bev Fau	ompleted on June 27, lkner,RN					
F0225 SS=D	have been found gor mistreating resid have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities.  The facility must eviolations involving abuse, including in and misappropriation reported immediate the facility and to with State law thro (including to the Stagency).  The facility must had leged violations a	ot employ individuals who juilty of abusing, neglecting, dents by a court of law; or entered into the State of concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing on the registry or licensing on the administrator of other officials in accordance ugh established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while					
	The results of all ir reported to the adr representative and accordance with S State survey and c working days of the	nvestigations must be ministrator or his designated to other officials in tate law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective					

000400

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155605 06/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1959 E COLUMBUS ST **GRANDVIEW HEALTH & REHABILITATION CENTER** MARTINSVILLE, IN46151 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on observation, interview, and F0225 Resident B was not harmed 07/08/2011 and was determined by a record review, the facility failed to ensure psychologist to be competent to a Qualified Medication Aide [QMA #1] make decisions for himself. immediately reported an allegation of Further, he stated he was a "willing participant." He was sexual misconduct between a resident monitored with one-on-one visits (Resident B) and an employee (LPN #1) by social services staff and of the facility. [QMA #1, Resident #B, showed no signs of mental and LPN #1]. anguish. Both QMA #1 and LPN #1 were suspended immediately once the facility administration Findings include: became aware of the events and were terminated upon completion In interview with the Assistant Director of the investigation. LPN #1 was of Nursing [ADoN] on initial tour of the reported by the facility to Licensure Board and the incident facility on 06/22/2011 at 10 a.m., the was seld-reported by the facility to ADoN indicated Resident #B was a young ISDH in an effort to ensure the resident, only 44 years old, was CNA/QMA Registry would be independent with ambulation and made aware of the incident, potentially resulting in action activities of daily living [ADL's], had against QMA #1.2. All residents anger behaviors toward staff and others, have the potential to be affected. was a little OCD [Obsessive Compulsive Alert and oriented residents were Disorder], jokes inappropriately, does like interviewed regarding abuse and staff treatment of residents with to touch others, but had no history of no negative findings and sexually acting out. non-interviewable residents were assessed from head to toe Review of Resident #B's clinical record to ensure no signs of abuse were evident. See below for corrective on 06/22/2011 at 12:50 p.m., indicated the measures.3. The policy and resident was admitted to the facility on procedures regarding resident 08/26/2010 and had diagnoses which abuse were reviewed and no included, but were not limited to, changes were indicated. Immediate re-education with staff Wernicke Korsakoff syndrome, from all departments was [Wenicke's encephalopathy implemented and completed. -encephalopathy associated with thiamine The Social Services Director or deficiency. Usually associated with her designee will interview five (5) residents weekly for four (4) chronic alcoholism, gastric carcinoma, or

000400

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155605	B. WIN			06/23/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		1959 E	COLUMBUS ST		
		EHABILITATION CENTER			NSVILLE, IN46151		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	+	TAG	weeks, then monthly for two	(2)	DATE
	hyperemesis gravidarum, loss of memory and disorientation with confabulation.				months, then quarterly there	. ,	
					The Administrator or her		
	Korsadoff's syndrome - personality characterized by a psychosis with polyneuritis, disorientation, muttering				designee will interview five (	•	
					staff members weekly for fou		
					weeks, then monthly for two months, then quarterly there		
	1	nia, illusions, and			(see attachment A). 4. The	ail <del>e</del> i.	
		Painful extremities, rarely			findings of these audits will b	е	
		drop, more frequently			reviewed during the facility's		
		pp with pain or pressure			quarterly Quality Assurance	:	
	over the long ne	rves. May occur as a			meetings and the plan of act adjusted accordingly.5. The		
	sequel to chronic	e alcoholism.],			above corrective measures		
	alcohol-induced	mental			completed on or before July		
	disorder/persisting	ng dementia, non-organic			2011.		
	psychosis, thiam	ine and niacin deficiency,					
	vitamin B12 def	iciency, alcohol					
		drome, alcohol abuse,					
	1 -	nemia, depressive					
	1 ' "	y, hypertension, arthritis,					
	insomnia, and co	· • •					
		QMA #1 on 06/23/2011 at					
	1 * '	ated a couple of months					
	ago, Resident #E	B told her LPN #1 and he					
	had sex. QMA #	‡1 indicated at first she					
	did not believe h	im and let it go for					
	awhile. QMA#	1 indicated of couple					
	weeks after that	she asked LPN #1 about					
	the incident and	she had told her they had					
	no physical contact - "He couldn't get it						
	aroused." QMA #1 indicated they were						
	off the clock when LPN #1 told her about this and indicated to her it happened once						
		ng to happen again. QMA					
	1	resident was still texting					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  GRANDVIEW HEALTH & REHABILITATION CENTER  ID  PROFIT  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  her about a month ago or less and he would get irate if she ignored the text.  Interview with LPN #1 indicated she was nice to him, did not feel like she had lead him on to think she wanted a relationship.  LPN #1 indicated the kissing happened once and she had no sexual contact with Resident #B would come up in the hall and "put his around me." LPN #1 indicated the resident exting her in March a lot, but was not personal texts. LPN #1 indicated the resident starded texting her in March a lot, but was not personal texts. LPN #1 indicated she was sorry it happened and it was an error in judgment. LPN #1 indicated she told only LPN #2 about the incident. LPN #1 indicated she did get suspended pending investigation and was terminated from the facility.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
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did get suspended pending investigation			-					
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			· · · · · · · · · · · · · · · · · · ·					
Observation of Resident #B was made on		Observation of R	tesident #B was made on					
06/22/2011 at 3:20 p.m. Resident #B was								
observed to be appropriately dressed, neat			*					
and clean in appearance, and was		1						
obviously younger than most of the								
residents in the facility. Interview with								
Resident #B at this time indicated he had			•					
been treated with dignity and respect								
during his stay at the facility. Resident #B								
indicated he knew LPN #1 and she mostly		1 -	-					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155605			LDING	NSTRUCTION  00	(X3) DATE S COMPL 06/23/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<b>"</b> {		1	ADDRESS, CITY, STATE, ZIP CODE		
CDAND	/IE\A/ LIEALTH & DE	EHABILITATION CENTER		1	COLUMBUS ST NSVILLE, IN46151		
					NSVILLE, IN40131		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	worked days, so	me evenings and some					
	nights. Resident						
	relationship with LPN #1 started out as						
	her being his nurse and talking. Resident						
	#B indicated LP	N #1 never initiated					
	anything that we	ent on between her and					
		nt #B indicated he did not					
	I -	ised. "Absolutely not."					
		esident #B indicated he					
		sex on numerous					
		nd oral sex. Resident #B					
		1 was a good nurse and					
		well. Resident #B					
		vere no other staff in					
	which he was in	volved with in a					
	relationship.						
	Review of a writ	ten statement by LPN #2,					
		1, indicated, "I was					
	approached 2-3	wks [weeks] ago about					
	QMA#1 and LP	N #1 texting Resident #B.					
	LPN #1 said that	t they had been texting					
	along time but n	othing sexual. She said					
	sometimes he ca	n be inapropriate [sic].					
	· ·	she ignored his text is					
		e, but he continues to text					
	1	on the floor (nurses)					
		him verbalizing having					
	1	oyees. On June 15, 2011,					
	_	th LPN #1 and she told					
	·	y for lying to me but that					
		ial contact with Resident					
		intercourse but contact. I					
	spoke with DON	the following day, June					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RCFV11 Facility ID:

000400

If continuation sheet

Page 6 of 15

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155605		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		155605	B. WIN			06/23/2	U11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CDANIDA	/IE\A/	HABILITATION CENTER		1	COLUMBUS ST NSVILLE, IN46151		
					NSVILLE, IN40151		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
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	16, 2011 around		+				
ı	10, 2011 around	о р.ш.					
	The facility's Inc	ident Report, dated					
	"	• '					
	06/16/2011 at 7:30 p.m., indicated QMA #1 was also involved, in that she was						
		tionship. The follow up					
	incident report, d						
	1 * 1	1 was terminated from					
	1	he was knowledgeable of					
	1 -	relationship and did not					
		_					
	report it to the facility administration.						
	OMA #1 was que	estioned by staff on					
	· •	g the investigation and					
		know LPN #1 had					
		B and she did not tell					
		ought the management					
	l -	QMA #1 indicated this					
		d awhile back when she					
	was off for surge						
	· ·	n asked why didn't she					
		about the incident, QMA					
	#1 responded, "I						
	"Trosponded, T	don't know.					
	The facility's pol-	icy on Reporting Alleged					
		vice Interventions, dated					
		ndicated, "All allegations					
	l •	or mistreatment will be					
		to the Administrator or					
	-	ee and a thorough					
	investigation will	_					
	_	pon occurrence, the					
		his/her designee is to be					
	immediately info	_					
		, <del></del>					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155605	A. BUILDING B. WING		06/23/2011		
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1959 E COLUMBUS ST  MARTINSVILLE, IN46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDERS PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE		
	Procedure dated " All reports of to the Administra within 24 hours of discovery of the responsibility of Hoosier Enterpria abuse situations, abuse and unusua circumstances, to is the employee's is reporting, the canother facility s Administrator.	use Prohibition, vestigation Policy and January 2006 indicated, Tabuse must be reported ator immediately of the reporting or incident It is the every employee of ses to not only report but also suspicion of al observations and/or o his/her supervisor. If it e supervisor the employee employee must notify upervisor or the facility relates to Complaint					
F0226 SS=D	written policies and mistreatment, neg and misappropriat Based on observatecord review, the staff did not cros	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. ation, interview, and e facility failed to ensure s the line of professional a resident and staff ed to have staff	F0226	Resident B was not harm and was determined by a psychologist to be competen make decisions for himself. Further, he stated he was a "willing participant." He was monitored with one-on-one v	it to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155605	B. WIN			06/23/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R			COLUMBUS ST		
GRAND	VIEW HEALTH & R	EHABILITATION CENTER			NSVILLE, IN46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	immediately report all alleged violations				by social services staff and		
	immediately to a	administrative			showed no signs of mental anguish. Both QMA#1 and	I DNI	
	management for	1 of 3 residents reviewed			#1 were suspended immedi		
	for reporting of	incidents and behaviors.			once the facility administrati		
	[Resident #B, Q	MA #1, and LPN #1]			became aware of the events	and	
		-			were terminated upon comp		
	Findings include	·			of the investigation. LPN #1	was	
	i manigs meraat				reported by the facility to Licensure Board and the ind	ا ماماد	
	In intervious suis	th the Assistant Director			was seld-reported by the fac		
					ISDH in an effort to ensure t		
		oN] on initial tour of the			CNA/QMA Registry would b		
	1 -	2/2011 at 10 a.m., the			made aware of the incident,		
		Resident #B was a young			potentially resulting in actior		
	resident, only 44	years old, was			against QMA #1.2. All resid		
	independent wit	h ambulation and			have the potential to be affe		
	activities of dail	y living [ADL's], had			Alert and oriented residents interviewed regarding abuse		
	anger behaviors	toward staff and others,			staff treatment of residents		
	~	O [Obsessive Compulsive			no negative findings and		
		inappropriately, does like			non-interviewable residents	were	
	3.0	but had no history of			assessed from head to toe		
	sexually acting of				to ensure no signs of abuse		
	Sexually acting (	out.			evident. See below for corre		
	D	1			measures.3. The policy and procedures regarding reside		
		dent #B's clinical record			abuse and codes of conduc		
		t 12:50 p.m., indicated the			reviewed and no changes w		
	resident was adr	nitted to the facility on			indicated. Immediate		
	08/26/2010 and	had diagnoses which			re-education with staff from		
	included, but we	ere not limited to,			departments was implement	ted	
	Wernicke Korsa	koff syndrome,			and completed. The Social Services Director or her des	innee	
	[Wenicke's ence	phalopathy			will interview five (5) resider		
	I -	associated with thiamine			weekly for four (4) weeks, th		
	deficiency. Usually associated with chronic alcoholism, gastric carcinoma, or hyperemesis gravidarum, loss of memory				monthly for two (2) months,		
					quarterly thereafter. The		
					Administrator or her designer interview five (5) staff memb		
		on with confabulation.			weekly for four (4) weeks, th		
		drome - personality			monthly for two (2) months,		
	1x013au011 3 Syll	arome - personanty			, , , , , , , , , , , , , , , , , , , ,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì		INSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
THIS TETAL	or connection	155605	- 1	LDING		06/23/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				COLUMBUS ST	
GRANDV	/IEW HEALTH & RE	HABILITATION CENTER		MARTIN	NSVILLE, IN46151	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)
	`		CROSS-REFERENCED T		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E
(X4) ID PREFIX TAG	summary statement of deficiencies (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  characterized by a psychosis with polyneuritis, disorientation, muttering delirium, insomnia, illusions, and hallucinations. Painful extremities, rarely a bilateral wrist drop, more frequently bilateral foot drop with pain or pressure over the long nerves. May occur as a sequel to chronic alcoholism.], alcohol-induced mental disorder/persisting dementia, non-organic psychosis, thiamine and niacin deficiency, vitamin B12 deficiency, alcohol dependence syndrome, alcohol abuse, hyponatremia, anemia, depressive disorder, anxiety, hypertension, arthritis, insomnia, and constipation.  Interview with QMA #1 on 06/23/2011 at 1:38 p.m., indicated a couple of months ago, Resident #B told her LPN #1 and he had sex. QMA #1 indicated at first she did not believe him and let it go for awhile. QMA #1 indicated a couple			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
		she asked LPN #1 about				
		she had told her they had act - "He couldn't get it				
		A #1 indicated they were				
	-	en LPN #1 told her about				
	this and indicated	d to her it happened once				
	_	g to happen again. QMA				
		resident was still texting				
		h ago or less and he				
	would get irate if	She ignored the text.				

000400

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION		(X3) DATE			
AND PLAN	OF CORRECTION	I	JMBEK:	A. BUIL	DING	00		COMPL	
		155605		B. WING				06/23/2	U11
NAME OF I	PROVIDER OR SUPPLIEF	\				DDRESS, CITY, STA			
OD AND	//E/A/ LIE A L T. L O. D.		OENITED.			COLUMBUS ST			
	/IEW HEALTH & RE					NSVILLE, IN4615	) I		
(X4) ID		STATEMENT OF DEFIC			ID		LAN OF CORRECTION E ACTION SHOULD BE		(X5)
PREFIX	` `	ICY MUST BE PERCEI . LSC IDENTIFYING IN			PREFIX TAG	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT CIENCY)	E	COMPLETION
TAG	<b>†</b>			-	IAG	DEF	CIENCI		DATE
	The facility's Inc								
	06/16/2011 at 7:30 p.m., indicated QMA								
	#1 was also involved, in that she was aware of the relationship. The follow up								
	incident report, o		-						
	indicated QMA								
	employment as s		~						
	the inappropriate								
	report it to the fa	cility administra	ition.						
	QMA#1 was qu	agtion ad by gtaff	r om						
	06/17/2011 durin	-							
	indicated she did								
	kissed Resident								
	anyone as she th								
	all aware. QMA								
	happened awhile								
	for surgery whic		ber.						
	When asked why								
	management abo		QMA#1						
	responded, "I do	n't know."							
	Intomvices:41. I	DNI #1 are 07/22	/2011 -4						
	Interview with L								
	3:45 p.m., indica								
	her at work. LP								
	nice to him, did								
	him on to think s		-						
	LPN #1 indicate								
	once and she had								
	Resident #B. LI	-							
	#B would come	-	-						
	around me." LP								
	resident started texting her in March a lot,								
	but was not pers	onal texts. LPN	#1						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete	Event ID:	RCFV11	Facility I	D: 000400	If continuation sl	neet Pa	ge 11 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155605		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 06/23/2	ETED	
NAME OF P	ROVIDER OR SUPPLIER	<u>"</u>	_		ADDRESS, CITY, STATE, ZIP CODE		
CDANDV	/IE\A/   IE A   TI   0 DE	THADILITATION CENTED			COLUMBUS ST		
		EHABILITATION CENTER			NSVILLE, IN46151		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		past month she did not		_			
	go into his room and she tried to avoid him. LPN #1 indicated she was sorry it						
		was an error in judgment.					
		d she told only LPN #2					
	about the incider	nt. LPN #1 indicated she					
	did get suspende	d pending investigation					
	and was termina	ted from the facility.					
		Resident #B was made on					
		20 p.m. Resident #B was					
		ppropriately dressed, neat					
	and clean in app						
		er than most of the					
		acility. Interview with					
		nis time, indicated he had					
		n dignity and respect					
	•	t the facility. Resident #B					
		w LPN #1 and she mostly					
	-	me evenings and some					
		#B indicated his					
	•	LPN #1 started out as see and talking. Resident					
	•	N #1 never initiated					
		nt on between her and					
		nt #B indicated he did not					
		ised - "Absolutely not."					
		esident #B indicated he					
		sex on numerous					
		id oral sex. Resident #B					
		1 was a good nurse and					
		well. Resident #B					
		vere no other staff in					
	which he was in	volved with in a					

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Event ID: RCFV11 Facility ID:

000400

If continuation sheet Page 12 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		100000	B. WIN			06/23/2	UTI
NAME OF F	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
CDANIDA	/IE\N/ HEALTH & DE	HABILITATION CENTER		l	COLUMBUS ST NSVILLE, IN46151		
					10 VILLE, 11 1 + 0 10 1		715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
-	relationship.		1	_			
ı	1 <b>3 1 1 1 1</b> 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
	Review of a writi	ten statement by LPN #2,					
	dated 06/17/2011, indicated, "I was						
		vks [weeks] ago about					
	_ ^ ^	N #1 texting Resident #B.					
	,	they had been texting					
		othing sexual. She said					
	sometimes he car	n be inapropriate [sic].					
	From that day on	she ignored his text is					
	what she told me	, but he continues to text					
	LPN #1. People	on the floor (nurses)					
	have mentioned l	him verbalizing having					
	sex with 2 emplo	yees. On June 15, 2011,					
	I was talking with	h LPN #1 and she told					
	me she was sorry	for lying to me but that					
	she had had sexu	al contact with Resident					
	#B. Not sexual i	ntercourse but contact. I					
	spoke with DON	the following day June					
	16, 2011 around	8 p.m."					
		icy on Reporting Alleged					
		vice Interventions, dated					
		ndicated, "All allegations					
		or mistreatment will be					
		to the Administrator or					
		ee and a thorough					
	investigation will	-					
		pon occurrence, the					
		his/her designee is to be					
	immediately info	rmed"					
	m e 11: 1 11	D 121.5					
	The facility's Abi						
	Reporting and In	vestigation Policy and					

<b>I</b> '		X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	LIA (X	2) MULTIPLE CON			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155605		BUILDING	00		06/23/20		
		100000	В.	WING			00123120	V 1 I	
NAME OF I	PROVIDER OR SUPPLIEF	R		I	DDRESS, CITY, STA				
GRAND	/IEW HEALTH & DE	EHABILITATION CENTE	R		COLUMBUS ST SVILLE, IN461				
								OLE:	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY F		ID PREFIX		LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMA		TAG	CROSS-REFERENCE	ED TO THE APPROPRIATI ICIENCY)	≣	DATE	
	<b>+</b>	d January 2006, indicate		-					
		f abuse must be reported	· ·						
	to the Administrator immediately								
	within 24 hours of the reporting or								
	discovery of the incident It is the								
	1	every employee of							
	1 -								
	Hoosier Enterprises to not only report abuse situations, but also suspicion of								
		al observations and/or							
		o his/her supervisor. If	f it						
			I .						
	is the employee's supervisor the employee is reporting, the employee must notify								
		supervisor or the facilit	.y						
	Administrator."	1							
	The psychologis	t completed an exam o	n						
	Resident #B on 0	06/17/2011 and							
	determined Resi	dent #B was competen	t to						
	make his own de	ecisions. Resident #B							
	affirmed to the p	sychologist that there	was						
	a sexual relation	ship with LPN #1.							
	The facility's em	ployee handbook with							
	revised date of N	November 2010 indicate	ed,						
	" We expect al	l employees to follow	our						
	established polic	cies, procedures, and ru	ıles						
	and to act in a pr	rofessional manner at a	.11						
	times" The ha	andbook had examples	of						
	impermissible co	onduct which included,	,						
	but was not limit	ted to, "Failure to repor	rt a						
	resident/employe	ee							
	accident/injury/i	ncident or otherwis	se						
	engaging in cond	duct that does not supp	ort						
		als and objectives.							
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Eve	ent ID: RCF	V11 Facility II	D: 000400	If continuation sh	eet Pac	ge 14 of 15	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155605		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COM	(X3) DATE SURVEY COMPLETED 06/23/2011	
NAME OF PROVIDER OR SUPPLIER  GRANDVIEW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1959 E COLUMBUS ST  MARTINSVILLE, IN46151			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE	
	federal laws and to report such no	aply with local, state, and /or regulations or failing on-compliance"  relates to Complaint				